October 16, 2020

Mr. Michael J. Laffey
Attorney
Laffey & associates, P.C.
415 Cartiers Avenue
Carnegie, Pennsylvania 15106

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432

Dear Mr. Laffey:

This is to acknowledge receipt of your request to appeal the Department's decision to Revoke the regular license and issue a First Provisional License for Dunlevy Manor. Your request has been forwarded to the Department of Human Services, Bureau of Hearings and Appeals. You will be contacted regarding the date and time of the hearing.

Sincerely,

Jeanne Parisi
Director

cc: Eugene Cuccarese (West), Office of General Counsel

Laffey & Associates, P.C.

ATTORNEYS AT LAW

415 Chartiers Avenue
Carnegie, PA 15106

800-827-8276
412-429-7079
Fax: 412-429-7078
mlaffey@subrogation.com

Michael J. Laffey ESQ.

August 28, 2020

Sent Via Facsimile and Priority FedEx
717-783-5662

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120

Re: Dunlevy Manor
2218 Route 88
Dunlevy, PA 15432
License #: 447541

Dear Mr. Patel:

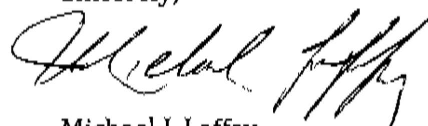
Please be advised that I represent TLC Healthcare with respect to the recent decision to issue a provisional license to Dunlevy Manor, License #: 447541.

Please consider this letter an official request for an Appeal with respect to the decisions of the Pennsylvania Department of Human Services (DHS) to issue a provisional license to Dunlevy Manor. My client disagrees with the DHS' decision to change its status to a provisional license and requests an appeal in accordance with 1 Pa. Code Part II, Chapters 31-35.

In particular, the Class II violation of 55 Pa. Code Chapter 2600 - 132d stemmed from an incorrect belief and certification by the fire department with respect to the time required by statute for full building evacuation. That matter has been corrected and documentation has been provided to DHS staff. Further, Dunlevy Manor management did not receive notification in any format with respect to violations identified in the LIS dated May 18, 2020. Responses to these violations will be submitted shortly however Dunlevy Manor was never made aware of these violations and proof of submission is hereby requested.

Please advise me of the date or process for the Appeal Hearing so that I may provide documentary proof for the hearing officer to review as part of the Appeal. If you have any comments or questions please do not hesitate to contact me directly.

Sincerely,



Michael J. Laffey
Attorney for Dunlevy Manor

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TLC HEALTHCARE LLC**
LEGAL ENTITY

To operate **DUNLEVY MANOR**
NAME OF FACILITY OR AGENCY

Located at **2218 ROUTE 88, DUNLEVY, PA 15432**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE
ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE
ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **24** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 18, 2020** until **February 18, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **447541**

Robert E. Robinson
ISSUING OFFICER

Jamie S. Buchenauer
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 6/20

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: August 18, 2020

Ms. Leah Laffey
Owner
TLC Healthcare, LLC
801 Elm Spring Road
Pittsburgh, Pennsylvania 15243

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432
License #: 447541

Dear Ms. Laffey:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on December 3, 2019, January 13, 2020, January 17, 2020 and May 18, 2020, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (447540) dated October 14, 2019 to October 14, 2020 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This FIRST PROVISIONAL license is also being issued based on your failure to submit an acceptable plan to correct the violations for the LIS dated May 18, 2020. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 18, 2020 to February 18, 2021.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
132d	II	16	$5	$80	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie L. Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Insurance Summary

Violation Report

Facility Information

Name: *DUNLEVY MANOR* License Number: *44754*
Address: *2218 ROUTE 88,, DUNLEVY, PA 15432*
County: *WASHINGTON* Region: *WESTERN*

Administrator

Name: *Leah Laffey* Phone: *7243265611* Email: *LLAFFEY@GMAIL.COM*

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: Total Daily Staff: *24* Waking Staff: *18*

Inspection

Type: *Partial* BHA Docket #: Notice: *Unannounced*
Reason: *Complaint*

Inspection Dates and Department Representative

12/03/2019 - On-Site: Karen Georgoulis

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* Residents Served: *16*

Secured Dementia Care Unit

In Home: *No*

Capacity: Residents Served:

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *8*
Are 60 Years of Age or Older: *16*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

5a1 - DHS Access

Regulations

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 12/3/19, the resident's assessments and support plans, to include resident #1 and #2, were not accessible or made available to the agent of the department from approximately 9:30 a.m. to 6:30 p.m.

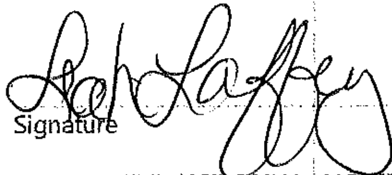
Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 2A of 13

See attachment

Legal Entity Representative



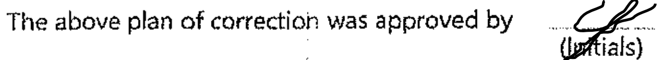
Signature

Leah Laffey administrator

Printed Name and Title

Date 2-13-2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!



The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by ____ (Initials)

5a1-DHS Access
2600 5.a. The administrator or a designee shall provide, upon request, Immediate access to the home, the residents and the record to: Agents of the Department. This allows Depart to measure compliance with all regulations.

On 12/3/19, the resident's assessment and support plans, to include resident # 1 and # 2, were not accessible or made available to the agent of the department from approximately 9:30 a.m. to 6:30 p.m.
This was able to happen because the Administrator was not in the office and the Assistant to the Administrator was not familiar enough with tabula pro to find the forms that were not in the file. The assessment and support plans were not in the residents file because there were no system put into place when the Old Administrator Susan DeLuca left.

A check list for new residents' sign and date for all new residents was created. There is a verification page that the will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. Donna Davis and Jody Knight have been selected as two staff to double check to make sure all residents files are completed. Both staff were trained on 2.11.2020 on Initial support plans and how to write them and when they are due. Administrator or the Assistant to the Administrator will take turns with each new resident and assign one of the two to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files and on time. Tabula Pro's dashboard calendar will be used to check what is due monthly looking ahead to the following month to make sure all documents are filled out on time. This will be done by the Administrator the first Monday of the month looking at the current month and the next month. The Assistant to the Administrator was taught by Nico from tabula pro and from the Administrator how to use tabula Pro to ensure if she has to find something in the future she will know how to get it.

Leah Laffey administrator 2-13-2020
Leah Laffey

3/25/2020

42c - Treatment of Residents

Regulations

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 12/3/18, interviews indicate direct care staff persons often yell at the residents, are sarcastic, speak harshly, call them names and address resident personal information in in front of other residents, as follows:
* Resident #1 ordered a fluid restricted diet. Resident #1 reported on several occasions during meals direct care staff, to include A would tell the resident he/she" didn't qualify' if asked for another drink or throw that fluid restriction in my face while other residents were present. Resident #1 stated, "they just didn't need to tell everyone."

* At approximately, 5:30 a.m., in mid-October, direct care staff person E while working the overnight shift (11:00 p.m. to 7:00 a.m.) had yelled at resident #3 and made the resident cry. Direct care staff started calling resident #3 a "cry baby" and had referred to the resident as a "cry baby" on several other occasions. Resident #3 reported being afraid of direct care staff E.

* Interviews indicate that direct care staff E, yells at the residents while getting them up in the morning, at approximately 5:00 a.m. on. Interviews indicate direct care staff E will yell "come on let's go, get up."

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 3A of 13

See attachment

Legal Entity Representative

Leah Laffey
Signature

Leah Laffey administrator
Printed Name and Title

2-14-2020
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by [initials] (Initials)

42 c- Treatment of Residents.
2600 42 c A resident shall be treated with dignity and respect. This is to ensure residents are treated in a respectful and dignified manner.
On 12/3/18, interviews indicated direct care staff persons often yell at the residents, are sarcastic, speak harshly, call them names and address resident personal information in front of other residents as follow:
Resident # 1 order a fluid restricted diet reported on several occasions during meals direct care staff, to include A would tell the resident # 1 in front of others they do not qualify for another drink throwing in her face that she didn't qualify for another drink because she was on fluid restriction.
Resident # 3 stated staff person E yelled at the resident making her cry. She then called her "cry baby" and has referred to resident # 3 as a "cry baby" on several occasions. She reported being afraid of staff person E.
Interviews indicated that direct care staff E, yells at the residents while getting them up in the morning yelling "come on let's go, get up."

A training for resident's rights was held on 01/08/2020 with Melissa Gorby Ombudsman. The resident's rights were addressed as well as Melissa going into detail about respect and dignity in order to address the concerns that have come out of the state interview. Learning how to be more sensitive to residents. Administrator completed a Growth and Change with staff E to address concerns that resident # 3 addressed with the State. A Growth and Change is to help supervisors work with staff if an issue has been identified to help change the behavior to prevent it from happening again. This was completed and put in staff E personal file. The Administrator also had a meeting with staff A and t was discussed that resident #1 does not want other residents hearing information about her medical issues with other residents. Resident # 1 will have all medical information discussed with her privately. And being more sensitive to residents that have different restrictions than everyone else. The Administrator also talked with resident # 1 about how she would like staff to alert her if she wants something that she is not permitted to have due to a doctor's order. And all staff were made aware of her request.

Leah Laffey Leah Laffey
Administrator 2-14-2020

3/25/2020

65a - FS Orientation 1st Day

Regulations

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Direct care staff person A started working in the home on 12/5/18. Direct care staff person A did not complete any of the required orientation in accordance with 2600.65(a) during the first day.

- Evacuation procedures.
- Staff duties and responsibilities, during fire drills, emergency evacuation, transportation.
- Designated meeting place.
- Smoking safety procedures.
- Location and use of fire extinguishers.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 4A of 13

See attachment

Legal Entity Representative

[signature]
Signature

Leah Laffey administrator 2-6-2020
Printed Name and Title — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by [initials] (Initials)

65a FS Orientation 1st Day

2600 65.a. Prior to or during the first day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that include: 1.Evacuation procedures, 2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. 3. The designated meeting place outside the building or within the fire- safety area in the event of an actual fire. 4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable. 5. The locations and use of fire extinguishers. 6. Smoke detectors and fire alarms. 7. Telephone use and notification of emergency services. This is to ensure all staff persons are immediately trained to respond to an emergency situation.

Direct care staff person A started working in the home on 12/5/18/ Direct care staff person A did not complete any of the required orientation in accordance with 2600. 65 a. during the first day. Evacuation procedures, staff duties and responsibilities, during fire drills, emergency evacuation, transportation. Designated meeting place, smoking safety procedures, and location and use of fire extinguishers.

The old administrator Susan Deluca is no longer and employee with Dunlevy Manor. Staff A stated she went over all the information on the first day but there was no documentation in the file. The orientation was completed with staff A on 2/6/2020. (Attached).
Moving forward an audit will be completed on all current personnel file and will be completed by 2/28/2020 to ensure all personnel files have everything they need in them for current employee's. The Administrator or the Assistant to the Administrator will be in charge of hiring, setting up start dates with new employees to ensure all staffing requirements are in the files and on time. A start date will be scheduled with the administrator or the assistant to the administrator and a minimum of 1 hour will be allotted to go over all First day hiring information in accordance with regulation 2600 65a.

Leah Laffey Leah Laffey administrator 2-6-2020

3/25/2020

65b - Rights/Abuse 40 Hours

Regulations

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Direct care staff person A started working in the home on 12/5/18. Direct care staff person A did not complete any of the required orientation in accordance with 2600.65(b) during the first 40-hour work week.

- Residents rights.
- Emergency medical plan.
- Mandatory reporting of abuse and neglect.
- Reporting of reportable incidents and conditions.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 5A of 13

See attachment

Legal Entity Representative

Leah Laffey
Signature

Leah Laffey administrator
Printed Name and Title

Date
2-11-2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by [initials] (Initials)

65b- Rights/abuse 40 hrs

2600 65 b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have and orientation that includes the following. This is to ensure that all staff persons working in the home are familiar with resident's rights, mandated reporting and the procedures for responding to a medical emergency.

Direct care staff person A started working in the home on 12.5.18. Direct care staff person A did not complete any of the required orientation in accordance with 2600. 65(b) during the first 40-hours of work week. Resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incident and conditions.

The old administrator Susan Deluca is no longer and employee with Dunlevy Manor. Staff A stated she went over all the information on the first day as well as the first 40 hours but there was no documentation in the file. The orientation was completed with staff A on 2/6/2020. (Attached).

Moving forward an audit will be completed on all current personnel file and will be completed by 2/28/2020 to ensure all personnel files have everything they need in them for current employee's. The Administrator or the Assistant to the Administrator will be in charge of hiring, setting up start dates with new employees to ensure all staffing requirements are in the files and on time. A start date will be scheduled with the administrator or the assistant to the administrator and a minimum of 1 hour will be allotted to go over all First day hiring information in accordance with regulation 2600 65a. After the orientation there will be a 40 hour training week that the new staff will shadow a veteran staff. The veteran staff will be assigned each day to go over sections of the 40 hour training to make sure all sections are completed and signed off on. After the 40 hrs the Administrator will meet with the staff to make sure all sections are completed and to see if the staff has any questions on anything learned because they start on the floor alone.

Leah Laffey Leah Laffey administrator
2-11-2020

3/25/2020

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation signed by the physician dated 9/22/19, does not indicate type of medical evaluation, the boxes are all blank. The form does not include the in-person evaluation date, the date form completion, height, special health and dietary needs, immunization history and body positioning/movement. These sections are all blank and the second page is missing.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 8A of 13

See attachment

Legal Entity Representative

Leah Laffey — Signature

Leah Laffey administrator — Printed Name and Title — 2-11-2020 Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

141a- Medical Evaluation

2600 141. a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner
2. Medical diagnosis including physical or mental disabilities of the resident if any
3. Medical information pertinent to diagnosis and treatment in as of an emergency
4. Special health or dietary needs of the resident
5. Allergies
6. Immunization history
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications
8. Body position and; movement stimulation for residents, if appropriate
9. Health status
10. Mobility assessment, updated annually or at the Department's request.

Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

Resident # 1's medical evaluation signed by the physician dated 09/22/19, DOES NOT INDICATE TYPE OF MEDICAL EVALUATION, THE BOXES ARE ALL BLANK. THE FORM DOES NOT INCLUDE THE IN- PERSON EVALUATION DATE, THE DATE FORM COMPLETION, HEIGHT, SPECIAL HEALTH AND DIETARY NEEDS, IMMUNIZATIONS HISTORY AND BODY POSITION/MOVEMENT. THESE SECTIONS ARE ALL BLAND AND THE SECOND PAGE IS MISSING.

Resident's # 1 DME was fixed by the Doctor and is attached. The error happened because no one talked with the Doctor when the DME was complete to let them know everything needed filled out in detail.

All resident files will be audited and completed by 3/2/2020 and anything missing will be corrected either by the home or the Doctor if it is on the Medical Evaluation section. The Administrator or the Assistant to the Administrator will make sure all DME's are filled out properly. It was discussed with the Doctor the home will have all the sections fill out on the DME except for the Medical Professional Information ahead of time to help the doctor's. Administrator talked with the Doctor to let them know what was missing on the DME and what information was needed to ensure next time they complete it thoroughly. The administrator or assistant to the administrator will Check all DME's after completion to ensure all information is filled out. If something is missed they will make sure they contact the Doctor to have all information filled out properly.

Leah Laffey Leah Laffey administrator
2-11-2020

3/25/2020

141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2, annual medical evaluation dated 1/18/19, does not include the resident's weight. The section is blank.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 9A of 13

See attachment

Legal Entity Representative

Leah Laffey — Signature

Leah Laffey administrator — Printed Name and Title

2-11-2020 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/28/2020 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

141b1- Annual Medical Evaluation

2600 141. b.1 A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department at least annually. Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

Resident #2, annual medical evaluation dated 1/18/19, does not include the resident's weight. The section is blank.

Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

The old administrator Susan DeLuca is no longer employed. An audit of all resident files will be completed by 3/2/2020. All DME's will be completed if something is missing either by the auditor or send to the Doctor if it is something in the Medical Professional section.

Moving forward The Administrator or Assistant to the Administrator will make sure all DME's are filled out properly. They will fill out all portions of the DME ahead of time except for the Medical Professional Information. The Administrator talked with the Doctor to let them know what was missing on the DME and what information was needed to ensure next time they complete it thoroughly as well as fix the ones that need information added. The Administrator or Assistant to the Administrator will check all DME's after completion to ensure all information is filled out. If something is missed we will make sure it is filled out or contact the Doctor to have all information filled out properly.

Leah Laffey   Leah Laffey 2-11-2020
administrator

224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1, admitted 9/21/19, does not have a preadmission screening completed.

Resident #2, admitted 1/8/16, does not have a preadmission screening completed.

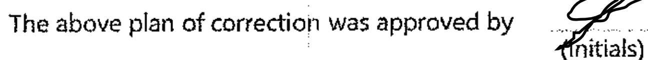
Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 10A of 13

See attachment

Legal Entity Representative



Signature

Leah Laffey Administrator 2-12-2020
Printed Name and Title Date

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The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by ______ (Initials)

224a- Pre admission Screen Form

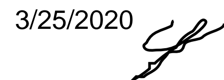
2600 224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home. This ensures the home can safely meet a resident's needs prior to admission.

Resident #1 admitted 9/21/19 and Resident #2 admitted 1/8/16 do not have a preadmission screening completed.

The prescreening documents were located on Tabula Pro and added to the file. The old administrator Susan DeLuca completed them but did not print them up for the files. (attached)

An audit is happening with all the resident files and will be completed by 3/2/2020. All residents files will be completed and any paperwork even if late will be completed.
A check list for new residents' sign and date for all new residents. There is a verification page that the will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. Donna Davis and Jody Knight have been selected as two staff to check to make sure all residents files are completed. Both were trained on 1.23.2019 on Initial support plans and how to write them and when they are due. I will take turns with each new resident and assign one of the three to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files and on time.

Leah Laffey Leah Laffey administrator
2-12-2020

3/25/2020 

225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #1, who was admitted to the home on 9/21/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 11A of 13

See attachment

Legal Entity Representative

Signature: Leah Laffey

Leah Laffey Administrator 2/12/2020
Printed Name and Title — Date

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The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

- [x] Implemented
- [ ] Not Implemented

The above plan of correction was approved by ____ (Initials)

225.a Assessment 15 Days

2600 225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form with 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.
This allows the home to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

An assessment was not completed for resident # 1, who was admitted to the home on 9/21/19.

All files are being audited and the audit will be completed by 3/2/2020. All files will be updated and all proper documentation will be placed in files.

The new administrator created a check list for new residents' sign and date for all new residents. There is a verification page that the will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. Donna Davis and Jody Knight have been selected as two staff to check to make sure all residents files are completed. All three were trained on 1.23.2019 on Initial support plans and how to write them and when they are due. I will take turns with each new resident and assign one of the three to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files and on time.

Leah Laffey Leah Laffey administrator
2-12-2020

During the plan of correction process the home provided an assessment for resident #1 dated 9/30/19.

3/25/2020

227a - Support Plan 30 Days

Regulations

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 admitted 9/21/19, does not have an initial support plan completed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 12A of 13

See attachment

Legal Entity Representative

Leah Laffey (Signature) — Leah Laffey administrator (Printed Name and Title) — 2-12-2020 (Date)

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The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by [initials] (Initials)

227.a Support Plan 30 Days
2600 227.a. A resident requiring personal services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form. This ensures that each resident's needs are met, and that accountability for meeting those needs is firmly established.

Resident #1 admitted 09/21/19, does not have an initial support plan completed. The old administrator Susan DeLuca did not have systems in place to ensure all paperwork would be completed in a timely manner. The Support plan was completed on Tabula Pro it was not printed and placed in files therefore it was unavailable in the file. (attached).

A check list for new residents' sign and date for all new residents was created. There is a verification page that the will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. Donna Davis and Jody Knight have been selected as two staff to double check to make sure all residents files are completed. Both staff were trained on 2.11.2020 on Initial support plans and how to write them and when they are due. Administrator or the Assistant to the Administrator will take turns with each new resident and assign one of the two to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files and on time. Tabula Pro's dashboard calendar will be used to check what is due monthly looking ahead to the following month to make sure all documents are filled out on time. This will be done by the Administrator the first Monday of the month looking at the current month and the next month.

Leah Laffey Leah Laffey 2-12-2020
Administrator

3/25/2020

252 - Record Content

Regulations

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #2 does not have a current picture in record. The most recent photograph is dated,1/8/16.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 13A of 13

See attachment

Legal Entity Representative

Leah Laffey
Signature

Leah Laffey Administrator 2-13-2020
Printed Name and Title Date

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The above plan of correction is approved as of 2/28/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by [initials] (Initials)

252- Record Content

2600. 252. Content of resident Records- Each resident's record must include the following information: 252 (3) A photo of the resident that is no more than 2 years old. Having a complete record for each resident gives the home the best possible picture of who the resident is, what the resident's history is, and what services or needs the resident may have.

Resident # 2 does not have a current picture in record. The most recent photograph is dated 01/08/16. A picture was taken and placed in the file. This was able to happen because when the Old Administrator Susan DeLuca left there was no systems in place to check that everything is in the files.

An audit is being conducted of all the files and will be completed by 3/2/2020. All residents will be given a new photo to keep everyone on the same date and year. Moving forward all new residents will receive a new photo however they will also have their picture updated when everyone who is a current resident now is updated to keep everyone on the same day. This will ensure all residents have a new picture on time. The next person that is up for a picture is due on 04/2/2020. All new photos will be taken and put into Tabula Pro on 3/30/2020 and that will be the date used moving forward. All new residents will have a picture taken at admission and then they will be on the rotation of 3/30/2022 to ensure all residents pictures are updated on time. 03/20/22 was added to Tabula Pro as a reminder to the Administrator that all Pictures are due by 3/31/2022.

Leah Laffey Leah Laffey Administrator
2-13-2020

3/25/2020

Violation Report

Facility Information

Name: *DUNLEVY MANOR* **License Number**: *44754*
Address: *2218 ROUTE 88,, DUNLEVY, PA 15432*
County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: *Leah Laffey* **Phone**: *7243265611* **Email**: *LLAFFEY@GMAIL.COM*

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: 6/20/96 **Issued By**: PA L&I

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *25* **Waking Staff**: *19*

Inspection

Type: *Partial* **BHA Docket #**: **Notice**: *Unannounced*
Reason: *Interim*

Inspection Dates and Department Representative

01/13/2020 - On-Site: Vicki Siegert, Cindy Mulick

01/17/2020 - On-Site: Vicki Siegert, Cindy Mulick

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *18*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *18*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *7* **Have Physical Disability**: *0*

25a - Written Contract and Review

Regulations

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

On 1/13/20, there was no resident-home contract completed for Resident #1 who was admitted to the home on 9/19/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

resident #1 was not admitted on 9/19/19. He was admitted on 11-15-19. (attached) is his contract. If you have any other questions please let me know.

The home's administrator provided the Department with documentation of resident #1's admission date of 9/19/19. The administrator provided a contract for resident #1 dated 11/11/19. 3/25/2020

By 4/1/2020: The administrator shall review all current resident records to ensure each resident has a resident-home contract completed and in each resident record. This will include ensuring completeness and accuracy of admission dates. 3/25/2020

By 4/1/2020: The administrator shall review the record for all new residents to ensure a resident-home contract is completed in accordance with regulation 2600.25(a). 3/25/2020

Legal Entity Representative

Leah Laffey — Signature
Leah Laffey administrator — Printed Name and Title
3-5-2020 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by ____ (Initials)

25b - Contract Signatures

Regulations

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #2 was admitted to the home on 11/6/19. The resident-home contract completed on 11/6/19 for resident #2 was not signed by the resident.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The home sent a corrected/signed contract for resident #2. 3/25/2020

See Page 3A of 21

Legal Entity Representative

Leah Laffey [signature] — Signature

Leah Laffey administrator — Printed Name and Title

3-25-2020 — Date

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The above plan of correction is approved as of 3/25/2020 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 3/25/2020 (Date)

[ ] Implemented
[X] Not Implemented

25b- Contract Signatures

Attached is the contract signed by resident.

This was able to happen because the old administrator left in September and the new administrator did not have systems in place. An audit is happening with all the resident files and will be completed by 3/20/2020. All resident's files will be completed and any paperwork even if late will be completed.
The administrator or designee will check files monthly to make sure all paperwork is completed on time and everything is fill out properly.

Leah Laffey Leah Laffey administrator 3-5-2020

3/25/2020

25c5 - Telephone Calls

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

5. The method for payment of charges for long distance telephone calls.

Description of Violation

Resident #2 had an additional resident-home contract, dated 11/11/19, with an adjusted monthly rate. This contract does not specify the method for payment of charges for long distance telephone calls.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

(attached) is resident #2 contract dated 11-6-2019. She had no addendum to her contract this is the only one that exists and it specifies the method for payment of charges for long distance telephone calls in section A. Charges. Please let me know if we need something else.

By 4/1/2020: The administrator shall review all current resident contracts for accuracy and completeness. 3/25/2020

By 4/1/2020: The administrator shall review all newly completed contracts for accuracy and completeness. 3/25/2020

Legal Entity Representative

Leah Laffey	Leah Laffey administrator	3-5-2020
Signature	Printed Name and Title	Date

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The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by ______ (Initials)

25c8 - Smoking

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

8. The home's rules related to home services, including whether the home permits smoking.

Description of Violation

Resident #2 had an additional resident-home contract, dated 11/11/19, with an adjusted monthly rate. This contract does not specify the home's rules related to home services including whether the home permits smoking.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

attached is resident #2 contract dated 1-16-2019. she had No addendum to her contract this is the only one that exists. and it specifies the smoking policy in the home IN section II Duties and responsibilitis of the resident B. House rules. Plese let me know if you need something else.

By 4/1/2020: The administrator shall review all current resident contracts for accuracy and completeness. 3/25/2020

By 4/1/2020: The administrator shall review all newly completed contracts for accuracy and completeness. 3/25/2020

Legal Entity Representative

Signature: [signature]

Printed Name and Title: Leah Laffey administrator

Date: 3-5-2020

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The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

25c12 - Bed Hold

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

Description of Violation

Resident #2 had an additional resident-home contract, dated 11/11/19, with an adjusted monthly rate. This contract does not specify the amount of the charges to the resident for holding a bed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

(attached) is resident #2 contract dated 11-6-2019. She had no addendum to her contract this is the only one that exists and it specifies in section A charges the amount for holding a bed. Please let me know if you need anything else.

By 4/1/2020: The administrator shall review all current resident contracts for accuracy and completeness. 3/25/2020 [initials]

By 4/1/2020: The administrator shall review all newly completed contracts for accuracy and completeness. 3/25/2020 [initials]

Legal Entity Representative

[signature] — Signature

Leah Laffey administrator — Printed Name and Title

3-5-2020 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

64c - Annual Training

Regulations

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, did not complete 12 hours of in-person training as part of his/her minimum required 24 hours of annual training relating to his/her job duties for the 1/1/19 - 12/31/19 staff training year.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

By 12/31/2020: The administrator shall complete 12 hours of Department-approved in-person administrator training during the 2020 training year in addition to the required 24 hours of Department-approved administrator training for the 2020 training year. 3/25/2020

See Page 7A of 21

Legal Entity Representative

Leah Laffey — Signature

Leah Laffey Administrator — Printed Name and Title

3-6-2020 — Date

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The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by ______ (Initials)

64 c annual trainings.

The administrator needs 24 hrs of annual training with 12 hrs being in-person training to ensure the administrator receives the highest quality training to continue to develop their knowledge or regulatory requirements and best practices in personal care home operation.

The administrator did not have the training in her file. (Attached is a copy of trainings) taken in 2019. These were all in person trainings.

The administrator will ensure she put all her trainings in her personal folder when they are completed and the personnel folders will be check and discussed during each quarterly quality management meeting to make sure they are in there for each calendar year.

Leah Laffey Leah Laffey

Administrator

3-6-2020

3/25/2020

127a - Portable Space Heaters

Regulations

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 1/17/20, at 2:02 p.m., there was a portable space heater plugged in and operating in resident bedroom #10. There was another space heater located in a closet in resident bedroom #11.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 8A of 21

Legal Entity Representative

Signature: Leah Laffey | Printed Name and Title: Leah Laffey Administrator | Date: 3/6/2020

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The above plan of correction is approved as of 3/25/2020 (Date)

The above plan of correction was approved by ________ (Initials)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

127a- Portable Space Heaters

Portable space heaters are prohibited. They are extremely dangerous, and have resulted in many fires. They can also burn residents that come in contact with them.

The space heaters were immediately removed from the premise. A Quality Management meeting on Feb 28th went into detail Fire drills and Space Heater to address any questions about the safety of the building. All staff were trained that space heaters are not permitted to be in the building under no circumstances. This will be discussed at each quality management meeting.

A fire safety training was competed in August and another one will be scheduled to ensure everyone working understands the seriousness of fire safety.

Administrator or designee will check weekly to make sure there are no space heater in the building and that there are no other fire safety violations.

Leah Laffey Leah Laffey

administrator 3-6-2020

3/25/2020

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record does not include the required documentation as follows:

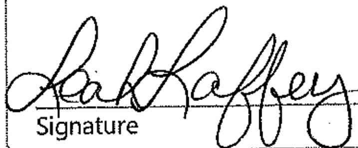
* Fire drill completed on 12/23/19 at "6am". However, the fire drill record did not indicate the exit routes used. *The letter from the Charleroi Fire Department regarding this fire drill indicates that the time of the drill was 05:55.
* Fire drill completed on 12/15/19 at "12N" does not indicate the exit routes used.
* Fire drill completed on 12/3/19 at "5pm" does not indicate the exit routes used.
* Fire drill completed on 11/3/19 at "10pm" does not indicate the exit routes used nor the number of residents evacuated.
* Fire drill completed on 11/30/19 at "11am" does not indicate the exit routes used nor the number of residents evacuated.
* Fire drill completed on 10/9/19 at "8pm" does not indicate the exit routes used nor the number of residents evacuated.
* Fire drill completed on 10/10/19 at "10am" does not indicate the exit routes used nor the number of residents evacuated.
* Fire drill completed on 9/23/19 at "7pm" does not indicate the exit routes used nor the number of residents evacuated.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 9A of 21

Legal Entity Representative



Signature

Leah Laffey administrator

Printed Name and Title

3-5-2020

Date

132 C-Fire Drill Record.
Recording fire drill information helps homes ensure compliance with all the regulations relating to fire drills, and to identify and correct problems with evacuation.

Attached is a copy of the fire drills with all the correct information on it. The administrator and assistant to the administrator had to research the RCG to ensure they understood the importance of ensure all accurate information is filled out. That fire drill for the year 2019 was talked in detail with the staff at the Quality Management meeting In February. The staff talked about what went wrong and after researching and understanding that if a fire drill is over the time limit another fire drill needs to be conducted the same day if possible. As well as extra fire drills in that month to ensure everyone is familiar with evacuation. A meeting with the residents took place as well to ensure everyone understands the importance of a fire drill and getting everyone out before the 4 minutes and 30 seconds. That was the only fire drill that the time was not met.
Fire drills are and will be discussed at each Quality Management Meeting to ensure everyone know all the protocol for the residents and a meeting with residents will happen quarterly to ensure the residents know as well what needs to be completed. The administrator will discuss Fire drills at the Quarterly Quality Management meeting to discuss any issues and ways to ensure all staff and residents are able to evacuate in the time allotted. The administrator will check fire drills monthly to ensure they are completed in the correct time and that all the correct information is filled out. Date, Time of the drill, Amount of time it took for the fire drill, Exit routes used, # of residents in the home at time of alarm, # of resident evacuated, # of staff participating, Was alarm activated, Was alarm Operative, Any problems, Planned corrective action.

Leah Laffey   Leah Laffey
Administrator
3-5-2020

3/25/2020

132c - Fire Drill Records *(continued)*

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The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by [signature] (Initials)

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's safe evacuation time designated in writing by a fire safety expert on 8/14/19 is 4 minutes, 30 seconds. However, the fire drill completed on 12/3/29 took 4 mins, 50 seconds to evacuate residents.

Repeat Violation 10/4/18 et al

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 11A of 21

Legal Entity Representative

[signature] Signature | Leah Laffey administrator — Printed Name and Title | 3-5-2020 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementati status as of 3/2/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

132 d- Evacuation
Evacuation within the maximum evacuation time prevents fire-related death and injury.

That fire drill on 12/03/2019 was talked in detail with the staff at the Quality Management meeting In February. The staff talked about what went wrong and after researching and understanding that if a fire drill is over the time limit another fire drill needs to be conducted the same day if possible. As well as extra fire drills in that month to ensure everyone is familiar with evacuation. A meeting with the residents took place as well to ensure everyone understands the importance of a fire drill and getting everyone out before the 4 minutes and 30 seconds. That was the only fire drill that the time was not met. All fire drills since the 8/14/19 fire drill has been completed within the correct time.
Fire drills are and will be discussed at each Quality Management Meeting to ensure everyone know all the protocol for the residents and a meeting with residents will happen quarterly to ensure the residents know as well what needs to be completed. The administrator will discuss Fire drills at the Quarterly Quality Management meeting to discuss any issues and ways to ensure all staff and residents are able to evacuate in the time allotted. The administrator will check fire drills monthly to ensure they are completed in the correct time.

Leah Laffey Leah Laffey
administrator 2-5-2020

By 4/1/2020: The administrator shall review the fire drill record monthly to ensure all fire drill evacuations are within the time specified in writing by the home's fire safety expert. 3/25/2020

By 4/1/2020: The home shall:
* Conduct at least two fire drills a month until the home can meet the safe evacuation time specified in writing by a fire safety expert within the past year, for three consecutive months.
* If the home exceeds the safe evacuation time specified in writing by a fire safety expert within the past year, for two consecutive fire drills, the home will add additional staff to the regular schedule and maintain the staffing level at all times. 3/25/2020

3/25/2020

141a - Medical Evaluation

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

On 1/13/20, there was no documentation of medical evaluation (DME) completed for resident #2 who was admitted to the home on 11/6/19.

On 1/13/20, there was no documentation of medical evaluation completed for resident #3 who was admitted to the home on 11/20/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 12A of 21

Legal Entity Representative

Signature: Leah Laffey

Printed Name and Title: Leah Laffey administrator

Date: 3-5-2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

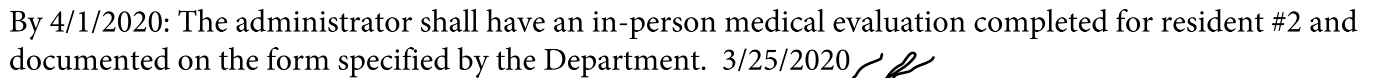
141a- Medical Evaluation

Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

Attached is residents #1 and resident # 3's medical Evaluations. The designee on the day of the inspection did not know how to go on tabula pro and print up the copy. There were no systems in place when the old administrator left and there was not a copy in the file.

All resident files will be audited and completed by 3/19/2020 and anything missing will be corrected either by the home or the Doctor if it is on the Medical Evaluation section. The Administrator or the Assistant to the Administrator will make sure all DME's are filled out properly. It was discussed with the Doctor the home will have all the sections fill out on the DME except for the Medical Professional Information ahead of time to help the doctor's. Administrator talked with the Doctor to let them know what was missing on the DME and what information was needed to ensure next time they complete it thoroughly. The administrator or assistant to the administrator will Check all DME's after completion to ensure all information is filled out. If something is missed they will make sure they contact the Doctor to have all information filled out properly. Administrator will check Tabula Pro monthly to make sure all correct information is completed.

Leah Laffey Leah Laffey administrator
3-5-2020



By 4/1/2020: The administrator shall have an in-person medical evaluation completed for resident #2 and documented on the form specified by the Department. 3/25/2020

3/25/2020

141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4 had a medical evaluation completed on 12/19/17. However, the resident's next medical evaluation was not completed until 1/21/19. The resident's medical evaluation completed on 1/21/19 does not include documentation of the resident's weight. This section is blank.

Resident #5's medical evaluation, completed on 1/12/19, does not include documentation of the resident's blood pressure or temperature. These sections were blank.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 13A of 21

Legal Entity Representative

[signature] Signature | Leah Laffey administrator Printed Name and Title | 3-5-2020 Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

141b1- Annual Medical Evaluation

Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

Attached is the 1/21/19/ DME as well as a 2018 DME dated 12/10/2018. There were no systems put in to place when the old administrator left in September.
An audit of all resident files will be completed by 3/20/2020. All DME's will be completed if something is missing either by the auditor or send to the Doctor if it is something in the Medical Professional section.

Moving forward The Administrator or Assistant to the Administrator will make sure all DME's are filled out properly. They will fill out all portions of the DME ahead of time except for the Medical Professional Information. The Administrator talked with the Doctor to let them know what was missing on the DME and what information was needed to ensure next time they complete it thoroughly as well as fix the ones that need information added. The Administrator or Assistant to the Administrator will check all DME's after completion to ensure all information is filled out. If something is missing the administrator or designee will make sure it is filled out or contact the Doctor to have all information filled out properly. Administrator or designee will check DME's monthly to make sure all blanks are filled in and all residents have DME's completed on time.

Leah Laffey

Leah Laffey
Administrator
3-5-2020

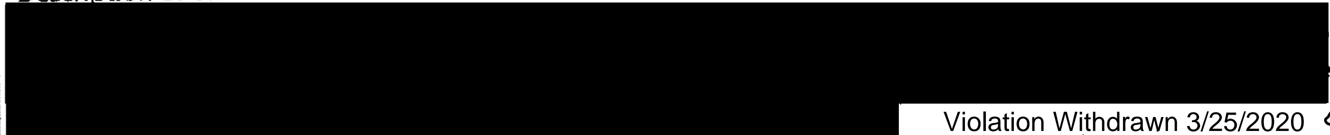
3/25/2020

183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation



Violation Withdrawn 3/25/2020

On 1/17/20, there was a bottle of Mucinex 600mg guaifenesin extended release bi-layer tablets with prescription label for resident #7 that indicates Mucinex ER 600mg tablet – take 1 tablet by mouth every 12 hours as needed for 10 days. The prescription was filled on 12/20/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 14A of 21

Legal Entity Representative

Signature: Leah Laffey
Printed Name and Title: Leah Laffey administrator
Date: 3-6-2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

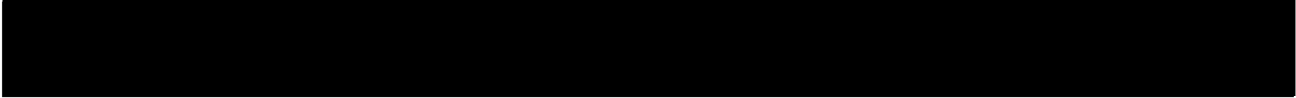
The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by ____ (Initials)

183d- Prescription Current
This is to ensure the home does not keep medications that are for residents no longer living in the home or that have been discontinued.



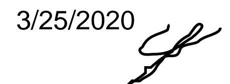
When talking with the Med tech they stated they were waiting for the pharmacy to come and take the Mucinex 600mg and did not have a process in place for what to do with meds when they were discontinued.

The head med tech has been working with the pharmacy to ensure all the medications are matching with the Med cart.

The week of 3/9/20 A Med tech who is certified to do med checks is coming in from another facility to do a cart audit on the cart and to do a medication med pass/training with the med techs to help them learn and understand what to do in these type of situation.

After the training the administrator or designee will check twice a month to make sure the med cart and MAR match up and will continue to do on the job training with med techs to ensure they understand all the responsibilities that go being a med tech.

Leah Laffey Leah Laffey administrator 2-6-2020



185a - Implement Storage Procedures

Regulations

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 1/17/20 at 2:33 p.m., resident #6's glucometer was not calibrated to the correct date and time. The glucometer for resident #6 indicated "1/16 14:25."

On 1/17/20 at 2:33 p.m., the incorrectly calibrated glucometer for resident #6 had a reading of 348 taken on 1/11 at 19:48. However, the corresponding entry for this reading on the resident's January 2019 MAR on 1/12/20 at 8:00 p.m. was 148.

On 1/17/20 at 2:52 p.m., resident #8's glucometer was not calibrated to the correct date and time. The Contour New EZ glucometer labeled for resident #8 indicated it was "16:02 1/16."

On 1/17/20 at 2:52 p.m., the incorrectly calibrated glucometer for resident #8 had readings which were incorrectly entered on the resident's January 2019 MAR as follows:
* Glucometer reading of 144 on 1/10 at 08:53; corresponding MAR entry for 1/11/20 at 9:00 a.m. is 166.
* Glucometer reading of 155 on 1/6 at 8:22; corresponding MAR entry for 1/7/19 at 9:00 a.m. is 118
* Glucometer reading of 174 on 1/3 at 8:48; corresponding MAR entry for 1/4/19 at 9:00 a.m. is 126

On 1/17/20 at 3:39 p.m., the glucometer for resident #7 had readings which were incorrectly entered on the resident's January 2019 MAR as follows:
* Glucometer reading of 175 on 1/14 at 5:39 p.m.; corresponding MAR entry for 1/14/19 at 5:00 p.m. is 174
* Glucometer reading of 128 on 1/7 at 8:24 a.m.; corresponding MAR entry for 1/7/19 at 9:00 a.m. is 120.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 15A of 21

Legal Entity Representative

Leah Laffey (signature) — Signature

Leah Laffey Administrator — Printed Name and Title

3-6-2020 — Date

185a- Implement Storage Procedures.

Ensure the residents receive medications and treatments as ordered by a physician.

All the glucometers have been re-calibrated and the MAR fixed to match the glucometers. The glucometers are being tested daily with the test solutions to ensure there are no errors.

A diabetic training has been scheduled with OSTPA for April. The medication training was completed in January (attached) and staff are getting on the job training weekly to ensure they understand glucometers.

The week of 3/9/20 A Med tech who is certified to do med checks is coming in from another facility to do a cart audit on the cart and to do a medication med pass/training with the med techs to help them learn and understand what to do in these type of situation. The pharmacy has been contacted and new glucometers have been order in case someone's will not calibrate. On 3/6/2020 talked with a member of the pharmacy and they will be coming in before April to do a cart audit and to do education teaching for the staff on the MAR system.

The administrator or designee will check twice a month to make sure the med cart and MAR match up and will continue to do on the job training with med techs to ensure they understand all the responsibilities that go with being a med tech.

Leah Laffey Leah Laffey Administrator 3-6-2020

3/25/2020

185a - Implement Storage Procedures *(continued)*

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The above plan of correction is approved as of 3/2/2020 (Date)

The above plan of correction was approved by [signature] (Initials)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented
☒ Not Implemented

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #6 is prescribed acetaminophen 325mg tabs – 2 by mouth every 8 hours as needed. On 1/17/20, the January 2020 medication administration record (MAR) entry for this medication indicates: acetaminophen 325mg – take 2 tablets by mouth every 4-6 hours as needed for mild pain or fever.

Resident #6 is prescribed medroxyprogesterone 5mg – 1 by mouth daily for inappropriate behaviors. However, on 1/17/20, there was no entry on the resident's January 2020 MAR for this medication. There was only an entry for medroxyprogesterone 10mg – take one tablet by mouth once a day for sexual behaviors.

On 1/13/20, resident #6 was prescribed Carbidopa-Levodopa 25-250mg OR tabs – take two tablets by mouth before meals. However, the only entry on the resident's January 2020 MAR for this medication indicates carbidopa/levodopa 25/250mg - Take 1 tablet by mouth four times a day for Parkinson's.

Repeat Violation 10/4/18 et al

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 17A of 21

187a- Medication Record

This is to ensure the home's staff persons will be able to track all medications a resident receives and to ensure all medications are administer as prescribed.

All violations have been corrected in the MAR. The pharmacy was contacted to make sure all the medications prescribe match the medications in the MAR.

A diabetic training has been scheduled with OSTPA for April. The medication training was completed in January (attached) and staff are getting on the job training weekly to ensure they understand glucometers.

The week of 3/9/20 A Med tech who is certified to do med checks is coming in from another facility to do a cart audit on the cart and to do a medication med pass/training with the med techs to help them learn and understand what to do in these type of situation. The pharmacy has been contacted and new glucometers have been order in case someone's will not calibrate. On 3/6/2020 talked with a member of the pharmacy and they will be coming in before April to do a cart audit and to do education teaching for the staff on the MAR system.

The administrator or designee will check twice a month to make sure the med cart and MAR match up and will continue to do on the job training with med techs to ensure they understand all the responsibilities that go with being a med tech.

Leah Laffey Leah Laffey Administrator 3-6-2020

3/25/2020

187a - Medication Record *(continued)*

Legal Entity Representative

Leah Raffey
Signature

Leah Laffey Administrator
Printed Name and Title

3-6-2020
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by [illegible] (Initials)

187b - Date/Time of Medication Admin.

Regulations

2600.
.187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 1/17/20 at approximately 1:00 p.m., there was an entry on resident #7's January 2020 medication administration record (MAR) for fluticasone propionate nasal spray – use 2 sprays into each nostril once a day as directed. This medication was not available in the home. According to staff person B, a medication technician, he/she does not know when the medication was last administered and states that it was not administered on 1/17/20 due to not being available. However, this medication was signed off as being administered by staff person B on 1/17/20 at 9:00 a.m.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 19A of 21

Legal Entity Representative

Leah Laffey (signature) — Signature
Leah Laffey Administrator — Printed Name and Title
3-6-2020 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

187b- Date/Time of Medication Administration

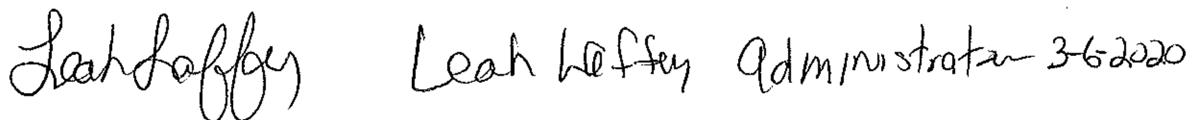
This is to ensure the home's staff persons will be able to track all medications a resident receives and to ensure all medications are administer as prescribed.

All violations have been corrected in the MAR. The medication was ordered and is in the Med cart and on the MAR.

The medication training was completed in January (attached) and staff are getting on the job training weekly to ensure they understand the Quickmar system and when to order medications.

The week of 3/9/20 A Med tech who is certified to do med checks is coming in from another facility to do a cart audit on the cart and to do a medication med pass/training with the med techs to help them learn and understand what to do in these type of situation.
On 3/6/2020 talked with a member of the pharmacy and they will be coming in before April to do a cart audit and to do education teaching for the staff on the MAR system and how to order medications before they runout.

The administrator or designee will check twice a month to make sure the med cart and MAR match up and to make sure all medications are available and will continue to do on the job training with med techs to ensure they understand all the responsibilities that go with being a med tech including contacting the pharmacies and Doctors when medication is running out.



3/25/2020

187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 1/6/20, resident #6 was prescribed medroxyprogesterone 5mg – 1 by mouth daily for inappropriate behaviors; the physician order indicated to discontinue the 10mg dose of this medication. However, on 1/17/20, according to staff person B, the home's designee and a medication technician, the resident was administered medroxyprogesterone 10mg – one tablet by mouth once a day from 1/7/20 through 1/17/20 according to the MAR entry for this medication.

On 1/13/20, resident #6 was prescribed Carbidopa-Levodopa 25-250mg OR tabs – take two tablets by mouth before meals. However, on 1/17/20, according to the resident's January 2020 MAR entry for this medication, the medication was administered as follows:
Cabidopa/levodopa 25/250mg – Take 1 tablet by mouth four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. from 1/14/20 through 1/17/20 at 8:00 a.m.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 20A of 21

Legal Entity Representative

Leah Laffey — Signature

Leah Laffey Administrator — Printed Name and Title

3-6-2020 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by [initials] (Initials)

187d- Follow Prescriber's Orders
2600 187 d. The home shall follow the directions of the prescriber. Ensure the residents receive medications and treatments as ordered by a physician.

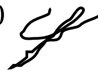
All violations have been corrected in the MAR. The Doctors office was contacted and the orders were confirmed and the pharmacy was contacted and the MAR was changed.

The medication training was completed in January (attached) and staff are getting on the job training weekly to ensure they understand the Quickmar system and when to call a doctor if the order does not match up with the MAR to ensure the resident is getting the medication as prescribed by a Dr.

The week of 3/9/20 A Med tech who is certified to do med checks is coming in from another facility to do a cart audit on the cart and to do a medication med pass/training with the med techs to help them learn and understand what to do in these type of situation.
On 3/6/2020 talked with a member of the pharmacy and they will be coming in before April to do a cart audit and to do education teaching for the staff on the MAR system and how to order medications before they runout.

The administrator or designee will check twice a month to make sure the med cart and MAR match up and to make sure all medications are available and will continue to do on the job training with med techs to ensure they understand all the responsibilities that go with being a med tech including contacting the pharmacies and Doctors when medication inconsistencies. To make sure the MAR and prescription match up correctly.

Leah Laffey Leah Laffey Administrator 3-6-20

By 4/1/2020: The administrator or designated staff person qualified to administer medications shall conduct a daily audit to ensure all prescriber's orders are followed. 3/25/2020 

3/25/2020

191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

On 1/13/20, there was no documentation that resident #1 was educated on the resident's right to question or refuse a medication if the resident believes there may be a medication error.

VIOLATION WOTHDRAWN 3/25/2020

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 21A of 21

Legal Entity Representative

Leah Laffey
Signature

Leah Laffey administrator
Printed Name and Title

3-26-2020
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/25/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by (Initials)

191 Resident right to refuse

Residents shall be educated of their rights and documentation shall be kept.

Resident # 1 signed his contract on 11-11-19 and on page 8 is the residents right to refuse medication that was signed on 11-11-19. That was not added later Z was on there the day the contract was signed.

This was able to happen because an old contract was used which did not have z. the right to refuse medication. All old contracts were disposed of and copies were made with a contract that has z on it to ensure all rights are available.

The administrator or designee will check the contracts when complete to make sure all proper information is available and all right are stated. Audits of the charts will be done quarterly.

Leah Laffey Leah Laffey administrator
3-6-2020

3/25/2020

Violation Report

Facility Information

Name: *DUNLEVY MANOR* **License Number**: *44754*
Address: *2218 ROUTE 88, DUNLEVY, PA 15432*
County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: *Leah Laffey* **Phone**: *7243265611* **Email**: *LLAFFEY@GMAIL.COM*

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: **Issued By**:

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection

Type: *Partial* **BHA Docket #**: **Notice**: *Unannounced*
Reason: *Complaint,Incident*

Inspection Dates and Department Representative

05/18/2020 - Off-Site: Scott Klein

05/19/2020 - Off-Site: Scott Klein

05/20/2020 - Off-Site: Scott Klein

05/22/2020 - Off-Site: Scott Klein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *16*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *16*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *2*
Have Physical Disability: *0*

16c - Written Incident Report

Regulations

2600.

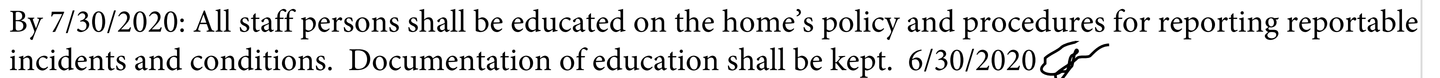
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 ceased to breathe on date of death #1, at approximately 12:50 a.m. The home did not report this incident to the Department until 4/21/2020 at 12:34 p.m..

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)


By 7/30/2020: All staff persons shall be educated on the home's policy and procedures for reporting reportable incidents and conditions. Documentation of education shall be kept. 6/30/2020

By 7/30/2020: The administrator shall review all reportable incidents and conditions weekly, to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16(c). 6/30/2020

Legal Entity Representative

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of ________ (Date)

Plan of correction implementation status as of ________ (Date)

☐ Implemented

☐ Not Implemented

The above plan of correction was approved by ________ (Initials)

227a - Support Plan 30 Days

Regulations

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

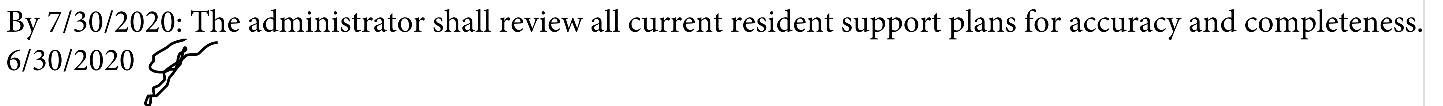
Description of Violation

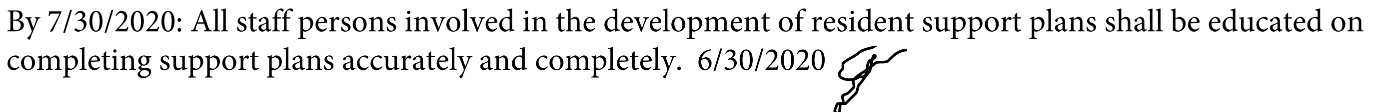
Resident #1's support plan, dated 9/30/19, does not indicate the care and services that Hospice is providing to the resident, the care and services the home will provide to manage the resident's diagnosis of unspecified combined systolic/diastolic heart failure, vitamin B-12 deficiency/anemia, and essential hypertension. The plan to meet medical need and responsible party sections of the support plan were left blank.

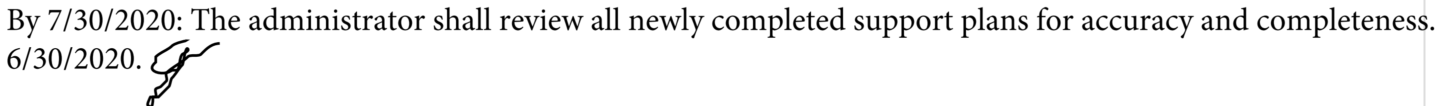
Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

By 7/30/2020: The administrator shall update resident #1's support plan. 6/30/2020


By 7/30/2020: The administrator shall review all current resident support plans for accuracy and completeness. 6/30/2020


By 7/30/2020: All staff persons involved in the development of resident support plans shall be educated on completing support plans accurately and completely. 6/30/2020


By 7/30/2020: The administrator shall review all newly completed support plans for accuracy and completeness. 6/30/2020.

Legal Entity Representative

Signature | Printed Name and Title | Date

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The above plan of correction is approved as of ________ (Date)

The above plan of correction was approved by ________ (Initials)

Plan of correction implementation status as of ________ (Date)

☐ Implemented

☐ Not Implemented

251c - Standardized Forms

Regulations

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

The incident report for resident #1's death, dated date of death #1, was not completed on the Department's current standardized form.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

By 7/30/2020: The administrator shall obtain the Department's current incident report form and make the for accessible to any staff reporting reportable incidents and conditions. 6/30/2020

By 7/30/2020: The administrator shall review all reportable incidents and conditions weekly, to ensure the Department's current form was used to report reportable incidents and conditions. 6/30/2020

Legal Entity Representative

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of ________ (Date)

☐ Implemented
☐ Not Implemented

The above plan of correction was approved by ________ (Initials)

252 - Record Content

Regulations

2600.
252. Content of Resident Records - Each resident's record must include the following information:
23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

The resident record for resident #1, who ceased to breath on date of death #1, does not contain a copy of the official death certificate.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

By 7/30/2020: The administrator shall review all current resident records to ensure all required information and documentation is present in each resident's record in accordance with regulation 2600.252. 6/30/2020

Legal Entity Representative

Signature | Printed Name and Title | Date

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The above plan of correction is approved as of ______ (Date)

Plan of correction implementation status as of ______ (Date)

☐ Implemented
☐ Not Implemented

The above plan of correction was approved by ______ (Initials)